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ABSTRACT

Predicated on the knowledge that effective communication among medical personnel and patients is fundamental to the achievement of successful health care delivery, this paper addresses the practice of chaplain intervention on behalf of the patient in primary care to enhance physician-patient interaction. First the paper defines culture (in the communicative context) as a "summation of ways of living, organizing, and communing built up in a group of human beings and transmitted to newcomers by means of verbal and nonverbal communication." The paper then considers: 1) the hospital culture; 2) patient functioning within that culture; and 3) the communicative role of the hospital chaplain in aiding patients. Following this, the paper contrasts the chaplain's role against his/her participation as a member of the health care team. The paper also discusses ways to improve communication, including programs or courses designed to provide training for health care professionals in humanistic disciplines. Twenty-five notes are included. (NKA)

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INTERVENING ON BEHALF OF THE PATIENT IN PRIMARY CARE: THE COMMUNICATIVE ROLE OF THE HOSPITAL CHAPLAIN AS A MEMBER OF THE HEALTH CARE TEAM

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INTERVENING ON BEHALF OF THE PATIENT IN PRIMARY CARE: THE COMMUNICATIVE ROLE OF THE HOSPITAL CHAPLAIN AS A MEMBER OF THE HEALTH CARE TEAM

Effective communication among medical personnel and patients is fundamental to the achievement of successful health care delivery. This premise has perpetuated significant research in the area of physician-patient interaction.[1] This paper will address the practice of chaplain intervention on behalf of the patient in primary care, in an effort to enhance physician-patient interaction, and a variety of areas which are directly related to such intentions. Areas to be discussed include the hospital culture, patient functioning within the hospital culture, the communicative role of the hospital chaplain in aiding patients, and contrasting this role against his/her participation as a member of the health care team.

Culture, in the communicative context, is a summation of ways of living, organizing, and communing built up in a group of human beings and transmitted to newcomers by means of verbal and nonverbal communication. An organization's culture is comprised of elements such as shared norms, rites, rituals, and stories that provide the members with a unique symbolic common ground.[2] Health care institutions exemplify such organizational cultures.

Knapp has reviewed an extensive amount of research which indicates the physical context, within which communication

occurs, can have a negative effect on perceived meanings.[3] For example, when patients enter huge structures, commonly referred to as medical centers, intimidation can begin before they even meet a health professional. This intimidation can be perpetuated by the internal environment which frequently includes maze-like hallways, desks used as barriers, paging systems, medical equipment, and an extensive use of antiseptic white. Similar effects, of the physical environment on human interaction, have been noted by other researchers.[4]

Aside from the physical environment, physician interpersonal involvement, expressiveness, and dominance can directly affect patient satisfaction and understanding.[5] While the content dimensions of interactions are central to outcomes of medical interviews, perceptions of relational qualities of these interactions are often more predictive of whether patients are satisfied with their health care and comply with physician recommendations.[6] For example, Buller reports that the physicians' communicative dominance is negatively related to the patients' satisfaction.[7]

Physician dominance, within physician-patient interaction, is frequently noted within the literature.[8] Mathews found that patients receive clues during interactions which inform them their questions are not welcome.[9] Mishler contends physician efforts to control discourse has the effect of absorbing and dissovling the patient's self-

understanding of his/her problems into the framework of technical medicine.[10] However, it should be noted passive and inactive physicians also elicit negative reactions from patients.[11] Overall, patients may seek more egalitarian interactions with physicians with both parties committed to contributing and responding.[12]

In 1972, the American Hospital Association developed a Patient's Bill of Rights. These rights were intended to "contribute to more effective patient care and greater satisfaction for the patient, his/her physician, and the hospital organization".[13] The Patient's Bill of Rights outlines 11 rights which are affirmed. Four of these rights deal specifically with interaction between the patient and his/her physician. These four rights are summarized as follows:

> #TWO The patient has the right to obtain from his/her physician complete current information concerning his/her diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand.
>
> #THREE The patient has the right to receive from his/her physician information necessary to give informed consent prior to the start of any procedures and/or treatment. Except in emergencies, such information for informed

consent should include, but not necessarily be limited to, the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation.

#FOUR The patient has the right to refuse treatment to the extent permitted by law, and to be informed of the medical consequences of his/her action.

#TEN The patient has the right to expect reasonable continuity of care. He/she has the right to know in advance what appointment times and physicians are available and where.[14]

The authors have recognized increased patient awareness of the Patient's Bill of Rights, but a frequent reluctance in asserting themselves to make inquiries of their physicians.

A primary approach for chaplains, in dealing with patients, is to serve as a listener.[15] As a listener, the chaplain can become acutely aware of areas of hospital care which the patient does not understand or objects to. Practitioners have acknowledged the practice of serving as an intermediary between patient and physician in such situations.[16]

Herman Knodt, Director of Pastoral Care at Grant Hospital in Columbus, Ohio, relates that sometimes patients

will complain to the chaplain but will be less likely to complain to the physician. An example, in such a situation, would be that the patient is too worn out to have too many tests run in a given period. Since the chaplain exercises extensive listening skills, he/she is more likely to be aware of such complaints than the physician. In such situations, the chaplain might talk with the physician, on behalf of the patient, depending on the relationship between the chaplain and the physician.

Before exploring the relationship between the chaplain and the physician, it is necessary to acknowledge the existence of mediating factors which make each patient unique. For example, the patient's anxiety about his/her medical condition can affect his/her preference regarding physician interpersonal involvement, expressiveness, and dominance. "Specifically, patients experiencing high anxiety express greater satisfaction with more involved, expressive, and dominant doctors and lower satisfaction with less involved, expressive and dominant practitioners than do patients experiencing low anxiety".[17]

Regardless of the mediating factors, chaplain intervention on behalf of the patient can affect the physician-chaplain relationship. For instance, chaplains have been accused by physicians of being overly optimistic regarding possibilities for the person being helped. Likewise, chaplains may often feel physicians are frequently

pessimistic. Different judgements, in these cases, can be understandably based on differences in training, background, and the ways in which professional goals are defined.[18] For instance, Lutheran health care literature states "In Christ's historical ministry, the healing of the soul and the curing of the body were irrevocably linked".[19] It is unrealistic to believe all health care providers subscribe to such a belief.

The sick patient is viewed from a number of perspectives. Physicians frequently view patients from a scientific perspective and ministers often view patients from a more philosophical or theological perspective. Granger Westberg, in hs book Minister and Doctor Meet, explains "Whenever they try to converse they find communication difficult because each looks at the patient's problem from his/her own perspective".[20]

The faith of the health care provider, chaplain or physician, can make a difference with some patients on treatment outcomes. "But even here the pastor must be careful that his/her faith is grounded in an understanding of realities, rather than in hopeful, but blind wishing".[21]

As a foundation for further discussion, it is necessary to clarify the formation of health care providers working as a team. Health care teams have evolved over the past 40 years. Three factors led to their development: 1) medicine has become more specialized and there is a need for specialists to work collectively as a team; 2) the technology

of medicine has become much more complicated and there is a need to integrate the talents of varied specialists to use this complicated technology; and 3) an increasing concern with the whole patient. That is, medical problems cannot be understood without looking at the patient as a person.[22]

It is essential for members of an interdisciplinary health care team to work together. But the potential for misunderstandings are usually greater among professions rather than within professions as individuals are not always aware of competencies and roles of team members from other professions. Overlapping roles, status differences, and conflicting viewpoints can easily lead to interprofessional conflict.[23] Thus, "Conflict and misperceptions among professionals can seriously interfere with collaborative efforts".[24]

Haselkorn cites three primary barriers to communication among professionals: 1) professional ethnocentrism, 2) differences in professional status, and 3) a lack of understanding of other professions.[25] The effectiveness of a health care team can depend on how well it deals with these areas. This effectiveness will be based on actions which are reactions to interprofessional perceptions.

Rubin and Beckhard stress the importance of expectations about the behavior of other team members. "Each person, in effect, has a set of expectations of how each of the other members should behave as the group works to achieve its

goals".[26] As these expectations are monitored against perceptions, conflicting viewpoints can understandably arise as the perception process is relative. For instance, Horwitz states the professional develops four images in his/her interaction with team members: 1) a personal and professional self-image; 2) expectations of his/her own profession in that setting; 3) an understanding of the skills and responsibilities of his/her colleagues; and 4) a perception of his/her colleagues' image of him/her.[27]

Steps have been taken by both pastors and physicians to decrease the perceptual distances which can exist between these two professions. In a study entitled "Cooperation Between Clergy and Family Practice Physicians: A New Area of Ministry", Robert Wikart describes a program which promoted a referral system between physicians and pastors. The program was based primarily on a series of breakfast meetings. His study indicates that familiarity, promoted through these meetings, facilitated the referral system.[28]

Another example is detailed in an article entitled "Pastoral Care of the Sick: A Clinical Course for Medical Students". This course was designed to address the dangers of the so-called "pre-med" syndrome, which is described as being a situation whereby certain types of individuals are consistently drawn into the medical sciences. The problem being that most pre-med students receive little formal training in humanistic disciplines. Thus, the course

(designed for medical students) deals with "discussion of religious issues and training in recognizing and responding to the spiritual situation of patients".[29]

In conclusion, the aforementioned efforts to improve physician-chaplain interaction seem to be based on a desired familiarity among the various members of the health care team. Using such familiarity as a base, health care team members can better work together to deliver effective health care. In the case of this article, such effectiveness has been addressed via chaplain intervention on behalf of the patient. As the influences of inter-professional familiarity are better understood, such familiarity can be more productively stressed within the health care team.

Notes

[1]R.L. Street and J.M. Wiemann, "Patients' Satisfaction with Physicians' Interpersonal Involvement, Expressiveness, and Dominance." Paper presented at the "Communicating with Patients" conference, Tampa, Florida, 1986, p. 1.

[2]E.G. Bormann in M. Pacanowsky and L.L. Putnam, Communication and Organizations: An Interpretive Approach (Beverly Hills: Sage Publications, 1983), p. 100.

[3]M.L. Knapp, Nonverbal Communication in Human Interaction (New York: Holt, Rinehart, and Winston, 1978).

[4]A. Baum and S. Valins, "Residential Environments, Group Size, and Crowding", Proceedings of the American Psychological Association, 1973, pp. 211-212; J. L. Freedman, "The Crowd, Maybe Not So Maddening After All", Psychology Today, 1971, pp. 58-61, 86; C. Haney and P.G. Zimbardo, "It's Tough to Tell a High School from a Prison", Psychology Today, 1975, pp. 2, 29; and D. Stokols, "The Experience of Crowding in Primary and Secondary Environments", Environment and Behavior, 1976, pp. 8, 49-85.

[5]Street and Wiemann, p. 1.

[6]Z. Ben-Sira, "The Function of the Professional's Affective Behavior on the Collection of Data", Journal of Health and Social Behavior, 17 (1976), pp. 3-11; and Z. Ben-Sira, "Affective and Instrumental Components on the Physician-Patient Relationship: An Additional Dimension of Interaction Theory", Journal of Health and Social Behavior, 21 (1980), pp. 170-180.

[7]M.K. Buller, Physician Communication Style and Health Care Satisfaction. Unpublished M.A. Thesis, Texas Tech University (1985).

[8]A.E. Beisecker, "Taking Charge: Attempts to Control the Doctor-Patient Interaction". Paper presented at the Second James Madison University Medical Communication Conference, Harrisonburg, Virginia, 1986.

[9]J.J. Mathews, "The Communication Process in Clinical Settings", Social Science Medicine, 17 (1983), pp. 1371-1378.

[10]E.G. Mishler, The Discourse of Medicine (Norwood, New Jersey: Ablex, 1984).

[11]M. Davis, "Variations in Patients' Compliance with Doctors' Advice: An Empirical Analysis of Patterns of Interaction", American Journal of Public Health, 58 (1968), pp. 274-288.

[12]Street and Wiemann, p. 21.

[13]A.H. Becker, The Compassionate Visitor (Minneapolis: Augsburg Publishing, 1985), p. 115.

[14]Becker, pp. 115-118.

[15]Becker, pp. 32-52; R.C. Cabot and R.L. Dicks, The Art of Ministering to the Sick (New York: The MacMillan Co., 1936), pp. 189-203. W.A. Clebsch and C.R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs, New Jersey: Prentice-Hall, 1964), pp. 53-54; and H. Clineball, Basic Types of Pastoral Counseling and Care (Nashville: Abingdon Press, 1984), pp. 205-206.

[16]The practice of chaplains serving as intermediaries between patients and physicians was described to the first author by Reverend Herman Knodt, Director of Pastoral Care, Grant Hospital (Columbus, Ohio). Interview, May 9, 1986.

[17]Street and Wiemann, p. 21.

[18]C.A. Wise, Pastoral Care: Its Theory and Practice (New York: Harper and Brothers, 1951), pp. 104-105.

[19]J.H. Wagner, "Mission and Ministry of Congregations in Health Care" in H.C. Letts (ed.) Health Care in America: A National Illness (Chicago: Lutheran Church in America, 1974), p. 103.

[20]G.E. Westberg, Minister and Doctor Meet (New York: Harper and Brothers, 1961), p. ix.

[21]Wise, p. 105.

[22]T.L. Thompson, Communication for Health Professionals (New York: Harper and Row, 1986), p. 24.

[23]A.J. Ducanis and A.K. Golin. The Interdisciplinary Health Care Team (Germantown, Maryland: Aspen Systems, 1979), p. 31

[24]H.D. Banta and R.C. Fox, "Role Strains of a Health Care Team in a Poverty Community", Social Science and Medicine, 6 (1972), pp. 697-722.

[25]F. Haselkorn, "Some Dynamic Aspects of Interpersonal Practice in Rehabilitation", Social Casework, 39 (1958), pp. 396-400.